AmeriHealth Caritas Iowa

# AmeriHealth Caritas Iowa
# Request for Prior Authorization
## Becaplermin (Regranex®)

Form applies to IA Health Link and ***hawk-i*** plans.

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

| | | | |
|---|---|---|---|
| AmeriHealth Caritas Iowa member ID #: | | Patient name: | |
| Patient address: | | | DOB: |
| Provider NPI: | Prescriber name: | | Phone: |
| Prescriber address: | | | Fax: |
| Pharmacy name: | | | |
| Address: | | | Phone: |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | | |
| Pharmacy NPI: | | Pharmacy fax: | NDC: |

Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet have a diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and inadequate response to 2 weeks of wound debridement and topical moist wound dressing. Payment for Regranex® for longer than 10 weeks will be authorized for patients when the wound has decreased in size by 30% after 10 weeks of Regranex® therapy.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

**Non-Preferred:**

☐ **Regranex**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

☐ Lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond.

☐ Other (specify):

Current wound measurements:

Diameter: **or** Height: and Width:

Is this a request to extend a prior authorization? ☐ No ☐ Yes

**If yes:**

Previous wound measurements:

Diameter: **or** Height: and Width:

Pertinent Lab data:

Additional relevant information:

Possible drug interactions/conflicting drug therapies:

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**Attach lab results and other documentation as necessary.**

| | |
|---|---|
| By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment. | |
| Prescriber signature:<br>(Must match prescriber listed above.) | Date of submission: |

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.